Health Care Price Transparency:
Updates and Reminders for Employers

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Since 2020, the U.S. government has implemented significant health care transparency laws aimed at helping plan sponsors evaluate health care spending and providing participants with greater insight into their cost-sharing for health care services. These requirements have slowly evolved as the Department of Health and Human Services, the Department of Labor and the Department of the Treasury (collectively, the departments) seek to streamline reporting, simplify requirements and glean actionable takeaways from available data. **This article summarizes the current key transparency requirements and discusses what the future may hold as health care fee litigation increases and as federal agencies continue to prioritize strict implementation and policy enforcement.**

Transparency in Coverage (TiC) final rule

The TiC rule was issued in October of 2020 by the departments in response to a health transparency executive order released by the first Trump administration. The rule aims to give consumers access to item and service-specific pricing information through their health plans. **It consists of two main requirements:**

COST COMPARISON TOOL

Plans must provide members with real-time estimates of their cost-sharing liability for covered items and services. This information must be provided via an internet-based self-service cost estimator tool. While the rule had a phased-in approach, ultimately, all items and services covered by a plan were required to be available via a self-service tool by January 1, 2024.

Most medical carriers had existing versions of this tool and worked to expand capabilities to meet the comprehensive TiC requirements and ensure ongoing data accuracy for covered items and services.

MACHINE-READABLE FILES

The TiC rule also required plans to publish three machine-readable files (MRFs) in a publicly available format with monthly updates. The files consist of information regarding:
1 negotiated rates for all covered items and services between the plan and in-network medical providers,
2 historical payments to and billed charges from out-of-network medical providers and 3 negotiated rates and historical net prices for prescription drugs covered by the plan.

The prescription drug MRF has not yet been implemented; the departments announced an enforcement delay due to an ongoing lawsuit and confusion on whether the MRF was duplicative of other prescription drug reporting requirements (see next section). Updated guidance implementing the prescription drug MRF is expected by October 2025.

Consolidated Appropriations Act (CAA) of 2021

The CAA of 2021 included several provisions aimed at further increasing price transparency through more detailed prescription drug reporting, broker compensation disclosure requirements and protections against surprise medical bills. The law also called for a member cost comparison tool. While this requirement was largely duplicative of the cost comparison tool required by the TiC rule, the CAA additionally clarified that this cost information must also be made available by telephone upon request. Thus, compliance with the TiC requirements (described above) is also sufficient for purposes of the CAA, so long as the information is also available by telephone.

The CAA also required specific actions by plan sponsors including:

PRESCRIPTION DRUG DATA COLLECTION (RxDC) REPORTING

Annually, by June 1, plans must provide specific reporting data on prescription drug spending to the departments. The report must include information like the plan's top 50 most costly drugs, top 50 most frequently dispensed drugs, total rebate amounts by therapeutic class, specific rebate information for the top 25 drugs with the highest dollar amount of rebates, etc. Utilizing the collective information reported, the departments began to biannually release an aggregated report on drug pricing costs and trends starting in 2023.

Although the legal obligation to report under the CAA falls on plan sponsors, the departments recognize that plans must look to pharmacy benefit managers and other plan service providers to assemble most of the information needed to complete the reporting. The departments allow multiple entities to enter reporting information on behalf of a particular plan. Reporting is submitted through the online Health Insurance Oversight System (HIOS) run by the Centers for Medicare and Medicaid Services (CMS), as CMS collects the CAA reporting data on behalf of the departments.

GAG CLAUSE PROHIBITION COMPLIANCE ATTESTATION

The CAA also prohibits health plans from entering into contracts that contain "gag clauses," which are provisions that restrict the disclosure of specific cost or quality information. Prohibited gag clauses include limits on the scope or frequency of electronic access to deidentified claims. Plan sponsors must attest that they have not entered into agreements containing such restrictions by December 31 annually. Similar to the RxDC reporting, these attestations are submitted via the CMS HIOS website.

This requirement indirectly regulates plan service providers by making it illegal for plans to work with them if their contracts contain gag clauses. Accordingly, plan sponsors should work with their plan service providers to ensure their contracts are compliant so that the attestation can be completed and filed annually. Employers Health's PBM contracts do not contain gag clauses and explicit language addressing this requirement is included in our master services agreement.

Transparency requirements and deadlines at a glance:

Transparency in Coverage final rules

- Member cost comparison tool (ongoing requirement)
- Machine readable files (ongoing requirement)
  1. In-network provider rates for covered items and services
  2. Out-of-network allowed amounts and billed charges for covered items and services
  3. Negotiated rates and historical net prices for covered prescription drugs*

**Requirement not yet implemented*

Consolidated Appropriations Act of 2021

- RxDC reporting (due annually by June 1)
- Gag clause prohibition compliance attestation (due annually by December 31)
- Member cost comparison tool (ongoing requirement)
- Broker compensation disclosure (ongoing requirement)

Looking forward: What's next in health care price transparency?

Earlier this year, President Trump issued an executive order titled "Making America Healthy Again by Empowering Patients with Clear, Accurate, and Actionable Healthcare Pricing Information." The order announced a continuation of his prior administration's focus on the TiC rules for hospitals and health plans by directing the departments to issue additional guidance on these requirements as well as implement the previously deferred prescription drug MRF. The departments responded less than 90 days later with Affordable Care Act FAQ Part 70, which addressed the forthcoming release of revised technical requirements for the MRFs that aim to eliminate duplicative data and reduce unnecessary fields to better contextualize data. The departments intend to finalize this guidance by October 1, 2025. Like in past transparency rule implementations, a series of CMS webinars will be available that explain the changes and provide technical assistance to plan sponsors.

What have we learned so far?

Compliance delays, data complexity and lack of patient awareness have lessened the initial impact of these transparency efforts. The MRFs are so massive and detailed that a standard computer is unable to open the files. While the member cost comparison tools were aimed at consumer price education and transparency, the objective behind the monthly publication of MRFs is for researchers to leverage these massive data sets to create more resources for health care purchasers and bring greater competition to the health care industry. However, in many instances, the MRFs lack consistent formatting, consist of estimates rather than "true" costs and contain sparse or duplicate information.

In May 2025, the departments issued several requests for information seeking commentary from stakeholders on how to update and improve the reporting format and data.

In November 2024, using aggregated data from the first two years of RxDC reporting, the departments released their initial report on prescription drug pricing trends and the impact of prescription drug rebates on patient out-of-pocket costs. Generally, the report found that gross drug prices have been growing more rapidly than prices net of rebates paid by manufacturers to PBMs. However, as with the MRFs, there were meaningful limitations with the initial years of reporting, which are being prioritized in future instruction templates. Additionally, vendors are encouraged to aggregate their book of business data at the state and market level, rather than each specific plan, and this has minimized the utility of this information for plan-specific insights.

Action items for employers

These reporting processes are very much still a work in progress. Moving forward, plans should be mindful of reporting deadlines and work with their plan service providers to ensure that all data will be submitted in a timely manner. Encouraging participants to take advantage of self-service cost estimator tools could minimize short-term cost-sharing liability for plan participants. This fall, plan sponsors should anticipate significant updates on the format of these reports from the Trump administration, although most of the compliance burden will fall to their plan service providers who will need to update standard reporting. Employers Health will continue to provide updates on new guidance and any reported findings from the departments.

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